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METHOD OF OBTURATION OF FISTULAS OF THE LARGE INTESTINE

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Reference: B. A. Bitsyn et al., Formed and Unformed External Fistulas, Novosibirsk, Nauka, 1985, pp. 68-71.

The invention relates to medicine, specifically to surgery, and can be used to treat external fistulas of the large intestine. The objective is a reduction of trauma in the obturation of fistulas that have a narrow, convoluted and long path. A conductor is introduced through the external fistula opening into the lumen of the intestine, captured with an endoscope introduced retrogradely, and withdrawn externally through the anal orifice, the obturating element is affixed to the conductor, and by drawing said element up to the internal fistula opening, the element covers it and is secured to a second obturating element that has been placed beforehand on the external fistula opening. The method makes it possible to carry out the occlusion of long, convoluted passages, which promotes faster healing. The method is recommended for practical use.

The invention relates to medicine, specifically to surgery, and can be used for treatment of external fistulas of the large intestine.

The objective of the invention is a reduction of trauma in the obturation of fistulas that have a narrow, convoluted and long passage.

The method is implemented in the following way.

First a fistulograph is made of the external fistula of the large intestine and one determines in the large intestine the localization of the external and internal fistula openings (which may be situated in the right or left half of the intestine), respectively, which are connected by a long convoluted passage, the diameter of fistula, the direction and length of the fistula path, and the presence of pockets. If there is a pocket along the path of the fistula, drainage of it is carried out beforehand. Depending on the localization of the fistula, in the right or left half of the large intestine, a fibrocolonoscope or rectoromanoscope is used.

A conductor in the form of fishing line is introduced into the lumen of the intestine through the external fistula opening along the long convoluted path and through the internal fistula opening. The tube of the rectoromanoscope with biopsator is introduced retrogradely through the anus into the large intestine up to the internal fistula opening and the fishing line introduced through it. The biopsator is used to capture the fishing line that has been passed through the external fistula opening and pulls it through the fistula passage into the lumen and then through the anus to the outside. Suture material with the obturating element in the form of a petal or plate is affixed to the fishing line that has been led externally and it is pulled with the fishing line up to the internal fistula opening. Thus, the positioned obturating element, while continuing to pull it toward the external fistula opening, is secured with the suture element to a second obturating element in the form of a spongy liner and plate, which is positioned before hand on the external fistula opening in the abdominal wall. As the internal obturating element is pulled toward the outer one the long convoluted fistula path is made shorter, and cutting of the fibrously altered walls of the fistula path by the suture material takes place, with subsequent

development of granulation and healing of the fistula path by second intention, which promotes faster healing of the fistula path and, therefore, reduces the treatment time. Any suture material can be used as suture material. Depending on the objective—silk is used in the case of presurgical treatment of the patient and operating field, while preference is given to catgut in the case of radical conservative treatment of the fistula, since when the suture material is removed through the fistula path to the outside of the abdominal wall there is injury to the walls of the fistula path and development of granulation in the wall of the path, with subsequent healing of the path and the fistula opening. The obturating element is eliminated from the large intestine in the act of defecation, the external obturating element, which covers the opening of the fistula path, also falls off as the fistula path closes and the catgut is absorbed.

Example. Patient T., a girl 15 years of age, was treated with the following diagnosis: external tubular fistula of the blind gut. The fistula graph revealed a fistula of the blind gut 0.5 cm in diameter and 12 cm long. Endoscopic retrograde obturation of the external tubular fistula of the blind gut with long convoluted path was carried out according to the proposed technique. The fistula of the blind gut had closed within 12 days, and as a result of healing of the fistula path the plate covering the internal fistula opening was eliminated in defecation and the plate covering the external fistula opening fell off.

The use of this method of obturation of fistulas of the large intestine makes it possible to carry out occlusion of long convoluted paths, which contributes to faster healing and to a reduction of treatment time.

Claim

A method of obturation of fistulas of the large intestine, which includes leading an obturating element up to the internal fistula opening, which is distinguished by the fact that, with the objective of reducing trauma in the obturation of fistulas that have a narrow, convoluted and long path, a thin conductor is introduced into the lumen of the intestine through the fistula path and is pulled externally through the anus with an endoscope, an obturating element is secured to the conductor, after which it is pulled behind the conductor up to the internal opening of the fistula path.